

		FOR OHF USE					

LL1

**2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0040931</u></p> <p>Facility Name: <u>COUNTRYSIDE CARE CENTRE</u></p> <p>Address: <u>2330 W. GALENA</u> <u>AURORA</u> <u>60506</u> Number City Zip Code</p> <p>County: <u>KANE</u></p> <p>Telephone Number: <u>(630) 896-4686</u> Fax # <u>(630) 896-7868</u></p> <p>IDPA ID Number: <u>36-3961908</u></p> <p>Date of Initial License for Current Owners: <u>07/01/94</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>SHAEL BELLOWS</u> (Title) <u>MANAGEMENT CONSULTANT</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>SHAEL BELLOWS</u> (Title) <u>MANAGEMENT CONSULTANT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>SHAEL BELLOWS</u> (Title) <u>MANAGEMENT CONSULTANT</u>																												
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																												

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,946	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,762	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	5,508	1,203	8,564	15,275	8
9	SNF/PED					9
10	ICF	43,979	10,132	2,625	56,736	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,487	11,335	11,189	72,011	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.05%

D. How many bed-hold days during this year were paid by Public Aid? 44 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 50 and days of care provided 4,861

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE** # **0040931** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	310,944	34,276	14,016	359,236		359,236	(10,834)	348,402		1
2	Food Purchase		259,187		259,187		259,187	(3,824)	255,363		2
3	Housekeeping	247,067	38,736		285,803		285,803	(612)	285,191		3
4	Laundry	58,294	29,304	3,576	91,174		91,174	(1,467)	89,707		4
5	Heat and Other Utilities			195,759	195,759		195,759		195,759		5
6	Maintenance	42,606	35,915	55,231	133,752		133,752	394	134,146		6
7	Other (specify):*			40,792	40,792		40,792		40,792		7
8	TOTAL General Services	658,911	397,418	309,374	1,365,703		1,365,703	(16,343)	1,349,360		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,417,106	141,138	84,722	3,642,966		3,642,966	(30,184)	3,612,782		10
10a	Therapy	71,776		1,830	73,606		73,606		73,606		10a
11	Activities	102,668	3,044	15,207	120,919		120,919	(2,476)	118,443		11
12	Social Services	49,811		10,140	59,951		59,951		59,951		12
13	Nurse Aide Training			620	620		620		620		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,641,361	144,182	118,519	3,904,062		3,904,062	(32,660)	3,871,402		16
	C. General Administration										
17	Administrative	189,124		846,710	1,035,834		1,035,834	(831,343)	204,491		17
18	Directors Fees										18
19	Professional Services			318,688	318,688		318,688	(194,850)	123,838		19
20	Dues, Fees, Subscriptions & Promotions			95,883	95,883		95,883	(60,910)	34,973		20
21	Clerical & General Office Expenses	157,513	44,126	57,001	258,640		258,640	179,813	438,453		21
22	Employee Benefits & Payroll Taxes			804,719	804,719		804,719		804,719		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,739	5,739		5,739	12,315	18,054		24
25	Other Admin. Staff Transportation			4,455	4,455		4,455		4,455		25
26	Insurance-Prop.Liab.Malpractice			196,258	196,258		196,258	26,384	222,642		26
27	Other (specify):*			176,260	176,260		176,260	(176,260)			27
28	TOTAL General Administration	346,637	44,126	2,505,713	2,896,476		2,896,476	(1,044,851)	1,851,625		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,646,909	585,726	2,933,606	8,166,241		8,166,241	(1,093,854)	7,072,387		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	11,950
	REPAIRS & MAINTENANCE		2,066
			0
			14,016
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		3,576
			0
			3,576
5	HEAT & OTHER UTILITIES		
	GAS HEAT		58,935
	ELECTRICITY		78,244
	WATER		58,580
	CABLE TV - LOBBY		0
			0
			195,759
6	MAINTENANCE		
	GROUNDS MAINTENANCE		7,842
	PAINTING & DECORATING		859
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		33,128
	ELEVATOR MAINTENANCE & REPAIR		3,796
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		5,940
	FIRE SERVICE		3,666
			0
			0
			0
			55,231
7	OTHER		
	SCAVENGER		39,147
	SECURITY SERVICE		1,645
			40,792
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000
			6,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,464
	PHARMACY CONSULTANT	XVIII B 39-2	2,200
	UTILIZATION REVIEW FEES	XVIII B 46-2	6,000
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	74,058
			0
			0
			84,722
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		1,622
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		208
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			1,830
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		12,528
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,679
			0
			15,207
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	9,000
	SOCIAL WORKER	XVIII B 45-2	1,140
			0
			10,140
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	620
			620

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	846,710
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	28,440
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	290,248
		0
		318,688
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	27,946
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,978
	EMPLOYEE WANT ADS XIX F	20,640
	CONTRIBUTIONS VI 20 XIX F	268
	DUES & SUBSCRIPTIONS XIX F	9,337
	LICENSES & PERMITS XIX F	2,352
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	14,781
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,117
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,464
		95,883
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,220
	EQUIPMENT REPAIR & MAINTENANCE	12,718
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	680
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	34,935
	MESSENGER SERVICE	1,448
		0
		57,001

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	349,756
	UNEMPLOYMENT COMPENSATION XIX D	60,073
	WORKERS COMPENSATION INSURANCE XIX D	106,523
	HOSPITALIZATION INSURANCE XIX D	266,154
	EMPLOYEE BENEFITS - OTHER XIX D	13,716
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	8,497
	CHICAGO HEAD TAX XIX D	0
		804,719
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	5,433
	TRAVEL XIX G	306
		0
		0
		5,739
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,455
		4,455
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	196,258
		196,258
27	OTHER	
	BAD DEBTS VI 24	176,260
		176,260

GRAND TOTAL COLUMN 3 OTHER 2,933,606

COUNTRYSIDE CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2004

TOTAL FOOD PURCHASE	259,187	PATIENT MEALS	216033
LESS SALES TAX	(3,824)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	255,363	TOTAL MEALS/YEAR	216033
TOTAL PATIENT CENSUS	72,011	NET FOOD	255363
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	216033

TOTAL PATIENT MEALS	216033	COST PER MEAL	1.18
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

COUNTRYSIDE CARE CENTRE

#0040931

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			136,369	136,369		136,369	149,672	286,041			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,328	133,328		133,328	285,241	418,569			32
33	Real Estate Taxes			141,936	141,936		141,936		141,936			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(719,947)	42,903			34
35	Rent-Equipment & Vehicles			22,649	22,649		22,649	9,695	32,344			35
36	Other (specify):* STORAGE			299	299		299		299			36
37	TOTAL Ownership			1,197,431	1,197,431		1,197,431	(275,339)	922,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,211	656,397	781,608		781,608		781,608			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,644	113,644		113,644		113,644			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		125,211	770,041	895,252		895,252		895,252			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,646,909	710,937	4,901,078	10,258,924		10,258,924	(1,369,193)	8,889,731			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(55,349)	30		9
10	Interest and Other Investment Income	(758)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,824)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(680)	21		18
19	Entertainment	(27,946)	20		19
20	Contributions	(6,385)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(24,419)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(176,260)	27		24
25	Fund Raising, Advertising and Promotional	(12,978)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(14,781)	20		28
29	Other-Attach Schedule	(31,337)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (354,717)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,014,476)	PG 6-6E	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,014,476)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,369,193)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1185	6	1
2	VACATION ACCRUAL	(10,834)	1	2
3	VACATION ACCRUAL	(612)	3	3
4	VACATION ACCRUAL	(1,467)	4	4
5	VACATION ACCRUAL	(791)	6	5
6	VACATION ACCRUAL	(6,568)	10	6
7	VACATION ACCRUAL	(2,476)	11	7
8	VACATION ACCRUAL	(9,572)	17	8
9	VACATION ACCRUAL	(202)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(31,337)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(10,834)	0	0	0	0	0	0	0	0	0	0	(10,834)	1
2	Food Purchase	(3,824)	0	0	0	0	0	0	0	0	0	0	(3,824)	2
3	Housekeeping	(612)	0	0	0	0	0	0	0	0	0	0	(612)	3
4	Laundry	(1,467)	0	0	0	0	0	0	0	0	0	0	(1,467)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	394	0	0	0	0	0	0	0	0	0	0	394	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,343)	0	0	0	0	0	0	0	0	0	0	(16,343)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,568)	0	(1,083)	0	(22,533)	0	0	0	0	0	0	(30,184)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,476)	0	0	0	0	0	0	0	0	0	0	(2,476)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9,044)	0	(1,083)	0	(22,533)	0	0	0	0	0	0	(32,660)	16
	C. General Administration													
17	Administrative	(9,572)	0	(410,312)	(308,594)	0	0	(102,865)	0	0	0	0	(831,343)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,419)	13,628	(54,995)	50,546	716	(180,326)	0	0	0	0	0	(194,850)	19
20	Fees, Subscriptions & Promotions	(62,090)	0	676	197	22	285	0	0	0	0	0	(60,910)	20
21	Clerical & General Office Expenses	(882)	287	65,205	334	1,538	113,331	0	0	0	0	0	179,813	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,932	606	2,850	2,927	0	0	0	0	0	12,315	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	19,208	2,941	472	1,753	2,010	0	0	0	0	0	26,384	26
27	Other (specify):*	(176,260)	0	0	0	0	0	0	0	0	0	0	(176,260)	27
28	TOTAL General Administration	(273,223)	33,123	(390,553)	(256,439)	6,879	(61,773)	(102,865)	0	0	0	0	(1,044,851)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(298,610)	33,123	(391,636)	(256,439)	(15,654)	(61,773)	(102,865)	0	0	0	0	(1,093,854)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(55,349)	196,614	4,387	0	140	3,880	0	0	0	0	0	149,672	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(758)	285,999	0	0	0	0	0	0	0	0	0	285,241	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(762,850)	19,070	0	1,234	22,599	0	0	0	0	0	(719,947)	34
35	Rent-Equipment & Vehicles	0	0	4,840	581	1,964	2,310	0	0	0	0	0	9,695	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(56,107)	(280,237)	28,297	581	3,338	28,789	0	0	0	0	0	(275,339)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(354,717)	(247,114)	(363,339)	(255,858)	(12,316)	(32,984)	(102,865)	0	0	0	0	(1,369,193)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		COUNTRYSIDE HEALTH CARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 762,850	COUNTRYSIDE HEALTH CARE CENTRE		\$	(762,850)	1
2	V	19 ACCOUNTING FEES		"		8,000	8,000	2
3	V	26 MORTGAGE INSURANCE		"		19,208	19,208	3
4	V	30 DEPRECIATION - BLDG/IMP		"		195,516	195,516	4
5	V	30 DEPRECIATION - EQPT/FURN		"		1,098	1,098	5
6	V	32 AMORTIZATION - MTG COST		"		1,283	1,283	6
7	V	32 INTEREST - MORTGAGE		"		259,514	259,514	7
8	V	32 INTEREST - OTHER		"		25,202	25,202	8
9	V	19 PROFESSIONAL FEES		"		5,628	5,628	9
10	V	21 OFFICE EXPENSES		"		287	287	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 762,850			\$ 515,736	\$ * (247,114)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 8,053	FHC ENTERPRISES, INC.		\$ 6,970	\$ (1,083)
16	V	17 ADMINISTRATIVE	435,251	MR. BELLOWS OWNS 1.5% OF THIS FACILITY		24,939	(410,312)
17	V	19 PROFESSIONAL FEES	55,402	AND 100% OF FHC ENTERPRISES		407	(54,995)
18	V	20 DUES & SUBSCRIPTIONS		" "		676	676
19	V	21 CLERICAL		" "		65,205	65,205
20	V	24 TRAVEL		" "		5,932	5,932
21	V	26 INSURANCE		" "		2,941	2,941
22	V	30 DEPRECIATION		" "		4,387	4,387
23	V	34 RENT		" "		19,070	19,070
24	V	35 RENT-EQPT & VEH		" "		4,840	4,840
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 498,706			\$ 135,367	\$ * (363,339)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 50,546	\$ 50,546
16	V	20 DUES & SUBSCRIPTIONS		"		197	197
17	V	21 CLERICAL		"		334	334
18	V	24 TRAVEL		"		606	606
19	V	26 INSURANCE		"		472	472
20	V	35 RENT - EQPT & VEH		"		581	581
21	V	17 ADMINISTRATIVE	308,594	"			(308,594)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 308,594			\$ 52,736	\$ * (255,858)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 66,006	CARLYLE NURSING ASSOCIATES, LLC		\$ 43,473	\$ (22,533)
16	V	19 PROFESSIONAL FEES		"		716	716
17	V	20 DUES & SUBSCRIPTIONS		"		22	22
18	V	21 CLERICAL		"		1,538	1,538
19	V	24 TRAVEL		"		2,850	2,850
20	V	26 INSURANCE		"		1,753	1,753
21	V	30 DEPRECIATION		"		140	140
22	V	34 RENT		"		1,234	1,234
23	V	35 RENT-EQPT & VEH		"		1,964	1,964
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 66,006			\$ 53,690	\$ * (12,316)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 186,270	THE KENSINGTON GROUP, LLC		\$ 5,944	\$ (180,326)
16	V	20 DUES & SUBSCRIPTIONS		" "		285	285
17	V	21 CLERICAL		" "		113,331	113,331
18	V	24 TRAVEL		" "		2,927	2,927
19	V	26 INSURANCE		" "		2,010	2,010
20	V	30 DEPRECIATION		" "		3,880	3,880
21	V	34 RENT		" "		22,599	22,599
22	V	35 RENT - EQPT & VEH		" "		2,310	2,310
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 186,270			\$ 153,286	\$ * (32,984)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$ 102,865	CHESTERFIELD LLC		\$	\$ (102,865)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 102,865			\$	0 \$ *	(102,865) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								\$		1
2	SHAEL BELLOWS	MANGMT. CNSLT	ADMIN.	0.02	SEE ATTACHED	0.06	0.39	SALARY	24,939	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,939		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2004

Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization FHC ENTERPRISES INC.
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	\$ 46,961	\$ 36,369	\$ 6,970	1
2	17	ADMINISTRATIVE	DIRECT HOURS	1	1	24,939	24,939	1	24,939
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739	36,369	407	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554	36,369	676	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460	36,369	14,762	5
6	21	CLERICAL	DIRECT HOURS	1	1	50,443	1	50,443	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971	36,369	5,932	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813	36,369	2,941	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557	36,369	4,387	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484	36,369	19,070	10
11	35	RENT - EQUIPENT & VEH.	PATIENT DAYS	245,034	9	32,607	36,369	4,840	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 479,528	\$ 71,900	\$ 135,367	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2004

Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization WITTINGHAM MANAGEMENT ASSOC, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	150,271	5	\$ 213,094	\$ 35,642	\$ 50,546	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	150,271	5	829	35,642	197	2
3	21	CLERICAL	PATIENT DAYS	150,271	5	1,408	35,642	334	3
4	24	TRAVEL	PATIENT DAYS	150,271	5	2,553	35,642	606	4
5	26	INSURANCE	PATIENT DAYS	150,271	5	1,990	35,642	472	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	150,271	5	2,448	35,642	581	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 222,322	\$	\$ 52,736	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2004

Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization CARLYLE NURSING ASSOC. LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0053
 Fax Number (847) 583-8873

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	\$ 285,631	\$ 35,642	\$ 43,473	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705	35,642	716	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142	35,642	22	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102	35,642	1,538	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724	35,642	2,850	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520	35,642	1,753	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917	35,642	140	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109	35,642	1,234	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	12,901	35,642	1,964	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 352,751	\$ 285,631	\$ 53,690	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2004

Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	\$ 39,055	\$ 35,642	\$ 5,944	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	1,870	35,642	285	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,608	660,461	113,331	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234	35,642	2,927	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205	35,642	2,010	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492	35,642	3,880	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483	35,642	22,599	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176	35,642	2,310	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,007,123	\$ 660,461	\$ 153,286	25

Facility Name & ID Number

COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10
		Related**					Purpose of Loan	Monthly Payment Required				
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE						\$	\$			\$	1
2	GMAC		X	MORTGAGE	\$60,450.43	12/03	4,826,200	4,782,499	12/38	0.0540	259,514	2
3	GMAC		X	LOAN COST	35 YR AMORT	12/03	52,135	44,896			1,283	3
4												4
5												5
	Working Capital											
6												6
7	LOAN - PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	171,696	DEMAND	VARIES	13,552	7
8	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	2,009,876	DEMAND	VARIES	144,978	8
9	TOTAL Facility Related				\$60,450.43		\$ 5,485,924	\$ 7,008,967			\$ 419,327	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,485,924	\$ 7,008,967			\$ 419,327	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		\$	106,812	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	123,696	2
3. Under or (over) accrual (line 2 minus line 1).		\$	16,884	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	125,052	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	141,936	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	92,112	8
	2000	94,448	9
	2001	97,597	10
	2002	105,650	11
	2003	123,696	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-19-176-009</u>	<u>NURSING HOME</u>	\$ <u>123,696.42</u>	\$ <u>123,696.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>123,696.42</u>	\$ <u>123,696.42</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2004 Ending:

12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CONST. Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>130,679</u>	<u>1981</u>	<u>\$ 98,000</u>	<u>1</u>
2	<u>754 BASIS ADJ.</u>		<u>1982</u>	<u>16,345</u>	<u>2</u>
3	TOTALS	130,679		\$ 114,345	3

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207	1981		\$ 2,111,156	\$	30	\$ 70,372	\$ 70,372	\$ 1,640,522	4
5										5
6	754 BASIS ADJ.		1992	403,542	12,811	31.5	12,811		160,138	6
7										7
8										8
	Improvement Type**									
9	*****RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE***									
10	BUILDING IMPROVEMENTS		1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS		1983	26,282		15			26,282	11
12	VINYL TILING		1984	76,250		20	1,907	1,907	76,250	12
13	ROOF REPAIR		1985	6,644	103	20	332	229	6,474	13
14	VARIOUS IMPROVEMENTS		1986	1,609	85	15		(85)	1,609	14
15	VARIOUS IMPROVEMENTS		1987	36,433	1,157	20	1,822	665	31,885	15
16	BLACK TOP PAVING		1988	1,594		15			1,594	16
17	HOT WATER PIPING		1988	5,837	185	31.5	185		2,999	17
18	ROOFING IMPROVEMENTS		1989	51,879	1,647	31.5	1,647		25,872	18
19	SHOWER STALLS		1990	7,000	222	31.5	222		3,219	19
20	PAVING		1990	7,930	529	15	529		7,670	20
21	VARIOUS IMPROVEMENTS		1991	24,486	777	20	1,224	447	16,532	21
22	VARIOUS IMPROVEMENTS		1992	43,773	1,390	31.5	1,390		17,239	22
23	VARIOUS IMPROVEMENTS		1993	13,286	421	31.5	421		4,991	23
24	VARIOUS IMPROVEMENTS		1993	40,598	1,041	39	1,041		11,753	24
25	VARIOUS IMPROVEMENTS		1994	214,320	5,494	39	5,494		55,904	25
26	VARIOUS IMPROVEMENTS		1994	62,476	4,167	15	4,167		43,750	26
27	KITCHEN REMODEL/SIGNS		1995	32,836	842	39	842		8,352	27
28	ELECTRICAL & LIGHTING		1995	31,634	811	39	811		6,788	28
29	ROOFING/DOORS/DUCTWORK		1995	15,211	390	39	390		3,280	29
30	ROOF REPAIRS/FIRE DAMPERS		1996	4,300	110	39	110		977	30
31	BLACK TOP PAVING		1996	3,400	87	39	87		707	31
32	DUCTWORK		1996	8,584	220	39	220		1,769	32
33	REMOVE & REPLACE HVAC ROOF UNITS		1998	28,363	727	39	727		4,574	33
34	ROOF REPAIRS - PATCHING		1998	6,500	167	39	167		1,148	34
35	STAINLESS DUCTWORK - KITCHEN EXHAUST		1998	3,987	102	39	102		710	35
36	BOILER		1998	6,556	168	39	168		1,113	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	\$ 58,243	\$ 2,118	27.5	\$ 2,118	\$	\$ 12,620	37
38	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		5,876	38
39	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL	1999	11,104	404	27.5	404		2,340	39
40	DINING RMS/WASHROOM - REMODEL/NEW ROOF	1999	165,984	6,035	27.5	6,035		34,451	40
41	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		7,971	41
42	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		5,276	42
43	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,624	27.5	4,624		25,240	43
44	IRRIGATION SYSTEMS/ BTY STATIONS	1999	26,058	947	27.5	947		5,090	44
45	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,661	27.5	30,661		159,697	45
46	REMODEL - OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		13,065	46
47	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		942	47
48	DOORS/LAUNDRY RM/CORRIDOR - REMODEL	2000	64,257	2,336	27.5	2,336		10,805	48
49	ELEVATOR OPERATION PANEL	2000	4,490	163	27.5	163		754	49
50	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		1,231	50
51	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		1,387	51
52	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		840	52
53	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		13,196	53
54	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		1,343	54
55	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		3,627	55
56	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		966	56
57	PARKING LOT EXPANSION	2000	35,624	1,295	27.5	1,295		5,558	57
58	GENERATORS	2000	92,626	3,368	27.5	3,368		14,174	58
59	LANDSCAPING/SECURITY PROJECT	2000	12,625	842	15	842		3,788	59
60	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,447	27.5	2,447		10,298	60
61	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		2,226	61
62	SIR FREE LINT FILTER	2000	1,399	51	27.5	51		215	62
63	NEW ROOF	2000	20,995	763	27.5	763		3,148	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767	27.5	3,767		15,539	64
65	ROOF REPAIRS	2000	3,300	120	27.5	120		495	65
66	ROOF REPAIR & METACAULK FIRE STRIP	2000	11,211	408	27.5	408		1,649	66
67	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		1,079	67
68	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		16,026	68
69	REMOVE/INSTL FLOOR & DRYWALL KITCHEN & LNDRY	2001	16,675	606	27.5	606		2,349	69
70	TOTAL (lines 4 thru 69)		\$ 5,426,228	\$ 110,741		\$ 184,276	\$ 73,535	\$ 2,587,438	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,426,228	\$ 110,741		\$ 184,276	\$ 73,535	\$ 2,587,438	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		465	2
3	INSTALL HYDRAULIC PUMPING UNIT-KITCHEN ELEVATOR	2001	7,495	273	27.5	273		1,035	3
4	REPLACE WATER CLOSETS 7 FLUSH VALVES-KITCHEN	2001	7,737	281	27.5	281		1,019	4
5	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	105	27.5	105		372	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		234	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LINE	2001	6,783	247	27.5	247		751	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	193	27.5	193		571	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HEATER	2002	14,988	545	27.5	545		1,612	9
10	SHOWER ROOM REPAIRS, REMOVE OLD & FURNISH/INSTALL NEW	2002	26,388	959	27.5	959		2,838	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		190	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		163	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	55	27.5	55		112	13
14	PARKING LOT - REMOVE AND REPLACE ASPHALT	2002	87,477	5,835	15	5,835		14,795	14
15	F&I ONE INFRARED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		80	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	48	27.5	48		74	16
17	INSTALL WATER SOFTENER	2003	2,400	87	27.5	87		127	17
18	S-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	349	27.5	349		509	18
19	SUPPLY & INSTALL WIRING FOR NEW 208-VOLT FREEZER	2003	1,651	60	27.5	60		78	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602,611,614,705,702	2003	3,666	133	27.5	133		139	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	500	27.5	500		500	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	31	27.5	31		31	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	50	27.5	50		50	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PROJECT	2004	3,751	125	15	125		125	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	861	27.5	861		861	25
26	COMPRESSOR	2004	2,100	22	27.5	22		22	26
27	NEW FIRE DOORS	2004	1,377	15	27.5	15		15	27
28	NEW AZT FLOOR TILES FOR RMS 806,812,303,512,313,314	2004	5,590	42	27.5	42		42	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	32	27.5	32		32	29
30									30
31			ADJ TO SL	73,535			(73,535)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,745,686	\$ 195,516		\$ 195,516	\$	\$ 2,614,280	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 913,560	\$ 86,479	\$ 76,290	\$ (10,189)	3-15 YRS	\$ 392,126	71
72	Current Year Purchases	87,606	49,890	4,730	(45,160)	3-15YRS	4,730	72
73	Fully Depreciated Assets	9,150					9,150	73
74	RELATED PARTY		9,505	9,505				74
75	TOTALS	\$ 1,010,316	\$ 145,874	\$ 90,525	\$ (55,349)		\$ 406,006	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,870,347	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 341,390	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,041	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (55,349)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,020,286	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **19,107** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE RAM PR 2W	\$ 295.13	\$ 3,542	17
18					18
19					19
20					20
21	TOTAL		\$ 295.13	\$ 3,542	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2005 \$ _____

13. _____ /2006 \$ _____

14. _____ /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
<p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 620	\$	\$ 620
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 620	\$	\$ 620
10	SUM OF line 9, col. 1 and 2 (e)	\$	620		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 263,549	\$		\$ 263,549	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			77,093			77,093	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			315,755			315,755	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				105,163		105,163	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): MEDICAL SUPPLIES	39-2					20,048		20,048	13
14	TOTAL			\$		\$ 656,397	\$ 125,211		\$ 781,608	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 204,798	\$ 337,142	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>121,610</u>)	1,823,511	1,823,511	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,688	120,047	6
7	Other Prepaid Expenses	29,027	29,027	7
8	Accounts Receivable (owners or related parties)	880	3,085	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		652,219	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,126,904	\$ 2,965,031	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,883	1,883	11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		3,230,985	15
16	Equipment, at Historical Cost	1,010,315	1,010,315	16
17	Accumulated Depreciation (book methods)	(836,243)	(3,509,237)	17
18	Deferred Charges		43,551	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CONSTRUCTION IN PROG.</u>		48,276	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 175,955	\$ 3,034,929	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,302,859	\$ 5,999,960	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,010,888	\$ 674,354	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	99,570	99,570	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,863	144,863	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,618	21,618	31
32	Accrued Real Estate Taxes(Sch.IX-B)		125,052	32
33	Accrued Interest Payable		21,521	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	5,017	5,017	36
37	<u>DUE TO DPA</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,281,956	\$ 1,091,995	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,181,572	2,298,319	39
40	Mortgage Payable		4,782,499	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,181,572	\$ 7,080,818	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,463,528	\$ 8,172,813	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,160,669)	\$ (2,172,853)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,302,859	\$ 5,999,960	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,388,838)	1
2	Restatements (describe):		2
3	ROUNDING ADJ	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,388,833)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	378,164	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 228,164	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,160,669)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,630,881	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,630,881	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	594	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,855	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,449	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	758	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 758	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,637,088	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,365,703	31
32	Health Care	3,904,062	32
33	General Administration	2,896,476	33
	B. Capital Expense		
34	Ownership	1,197,431	34
	C. Ancillary Expense		
35	Special Cost Centers	781,608	35
36	Provider Participation Fee	113,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,258,924	40
41	Income before Income Taxes (line 30 minus line 40)**	378,164	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 378,164	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,916	2,131	\$ 85,312	\$ 40.03	1
2	Assistant Director of Nursing	2,834	3,179	94,510	29.73	2
3	Registered Nurses	29,217	32,046	886,049	27.65	3
4	Licensed Practical Nurses	20,760	23,258	579,439	24.91	4
5	Nurse Aides & Orderlies	110,739	118,339	1,612,371	13.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,818	5,199	71,776	13.81	8
9	Activity Director	1,977	2,173	30,726	14.14	9
10	Activity Assistants	7,477	7,982	71,942	9.01	10
11	Social Service Workers	3,342	3,679	49,811	13.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,832	11,100	147,154	13.26	14
15	Cook Helpers/Assistants	19,459	20,408	163,790	8.03	15
16	Dishwashers					16
17	Maintenance Workers	1,999	2,206	42,606	19.31	17
18	Housekeepers	25,309	27,487	247,067	8.99	18
19	Laundry	5,721	6,338	58,294	9.20	19
20	Administrator	1,933	2,246	138,146	61.51	20
21	Assistant Administrator	1,884	2,214	50,978	23.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,190	10,114	157,513	15.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,950	7,896	159,425	20.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	265,357	287,995	\$ 4,646,909 *	\$ 16.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	240	\$ 11,950	1-3	35
36	Medical Director	36	6,000	9-3	36
37	Medical Records Consultant	56	2,464	10-3	37
38	Nurse Consultant	492	74,058	10-3	38
39	Pharmacist Consultant	88	2,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	24	2,679	11-3	44
45	Social Service Consultant	116	10,140	12-3	45
46	Other(specify) <u>UTILIZATION REV</u>	36	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,088	\$ 115,491		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Nurse Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
KIM KOHLS	ADMIN		\$ 138,146	Workers' Compensation Insurance	\$ 106,523	IDPH License Fee	\$		
VIVIAN MC CAIN	ASST ADMIN		50,978	Unemployment Compensation Insurance	60,073	Advertising: Employee Recruitment	20,640		
				FICA Taxes	349,756	Health Care Worker Background Check (Indicate # of checks performed _____)	1,464		
				Employee Health Insurance	266,154	MARKETING/ADV/PROMO	55,705		
				Employee Meals	0	TRUST/FRANCHISE/CONTRIB/ETC	6,385		
				Illinois Municipal Retirement Fund (IMRF)*		LICENSES & PERMITS	2,352		
				EMPLOYEE BENEFITS - OTHER	13,716	DUES & SUBSCRIPTIONS	9,622		
				EMPLOYEE PHYSICAL EXAMS	0	MGMT CO ALLOCATION	895		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 189,124	PENSION/PROFIT SHARING PLANS	8,497	TRUST/FRANCHISE/CONTRIB/ETC	(6,385)		
				CHICAGO HEAD TAX	0	Less: Public Relations Expense	(27,946)		
				INSURANCE - EXECUTIVE LIFE	0	Non-allowable advertising	(12,978)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Yellow page advertising	(14,781)		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 804,719	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,973		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
RELATED PARTIES	MANAGEMENT FEES		\$ 846,710			\$	Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 846,710				In-State Travel		
							TRAVEL	306	
							RELATED PARTY	12,315	
							Seminar Expense		
								5,433	
							Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8))	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 318,688	TOTAL		\$	TOTAL	\$ 18,054	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	2001	\$ 2,369		\$ 395	\$ 790	\$ 790	\$ 394	\$	\$	\$	\$	\$												
2	PAINT/DECORATING	2002	2,374			396	791	791	396																
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									
16																									
17																									
18																									
19																									
20	TOTALS		\$ 4,743		\$ 395	\$ 1,186	\$ 1,581	\$ 1,185	\$ 396	\$	\$	\$	\$												

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LTC - \$11536.80
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,732 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 113,644
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees